LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
(LSBME)
Main Phone: (504) 568-6820 (auto attendant)

PHYSICIANS, OSTEOPATHS, AND PODIATRIST

APPLICATION AND INSTRUCTIONS

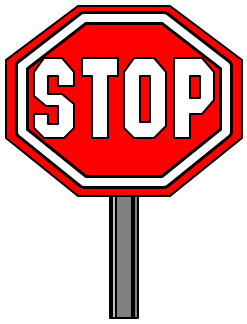
(Rev. 010505)

***Visit the LSBME website at* www.lsbme.louisiana.gov**

Application Processing Addresses:
LSBME, P.O. Box 54403, New Orleans, LA 70154-4403

Criminal Background Check Address:
LSBME, ATTN.: CB, P. O. Box 30250, New Orleans, LA 70190-0250

Physical Address:
630 Camp Street, New Orleans, LA 70130



PLEASE READ FIRST

The Louisiana State Board of Medical Examiners (the "Board") annually processes hundreds of applications for licensure. This process involves the collection of credentials from the applicant as well as other sources. The Board conducts a thorough evaluation of credentials, employment or work history, malpractice history and disciplinary history. This process takes time - anywhere from a few weeks to several months, depending upon how quickly the applicant complies with what is requested and the nature of any problems requiring closer attention. Licensure is not guaranteed. As such, each applicant is advised not to make commitments on loans, practice start dates, home purchases, etc. The Board will not accelerate one application at the expense of another nor will it waive any requirements in the screening process. Once the application is received and reviewed, the analyst prepares and sends out a missing document report to request additional information and/or to return items that need corrections or clarifications. Please wait at least thirty days before calling to check on the status of the application. The Board has no control over materials that must be requested from other agencies. The Board shall have a reasonable period of time to collect and assimilate all required documents and information necessary to issue a license. If after submitting an application for licensure, an applicant has failed to respond or make an effort to pursue licensure for a period of six months, the application will be null and void and the applicant must reapply. If you have been named in a malpractice suit, been sanctioned by another state or agency or have answered "yes" to any of the questions on the oath and affirmation page of the application, you must provide a detailed notarized narrative of the incident and anticipate a delay in the licensing process. This includes offenses that may have occurred as a juvenile and that may have been expunged from your record. The criminal background check can take months to process. As such, it is suggested that you request the criminal background materials as soon as you know that you are relocating to Louisiana.

Qualifications for Licensure - International Medical Graduates

- Be at least 21 years of age and of good moral character;
- Be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service;
- Possess a Doctor of Medicine degree duly issued by a medical school approved by the board. This diploma must be in English; if not, must be accompanied by a certified translation into English;
- Applicant must have completed three years of ACGME approved residency training in the United States or Canada in the same specialty;
- Have taken and passed FLEX/USMLE Steps 1, 2, and 3 or a combination thereof. Examination cannot have been taken more than four times;
- Have taken and passed the ECFMG examination and have a valid certificate;
- If a medical competency examination has not been taken within 10 years of application, the applicant must be board certified or re-certified through the American Board of Medical Specialties within the past ten years or the applicant must take and pass SPEX (Special Purpose Examination) administered through the Federation of State Medical Boards, Inc.

Qualifications for Licensure - U.S./Canadian Graduates

- Be at least 21 years of age and of good moral character;
- Be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service;
- Possess a Doctor of Medicine degree duly issued by a medical school approved by the Board. The diploma must be in English. If not, must be accompanied by a certified translation into English;
- Completed a year of ACGME approved internship training in the United States or Canada;
- Have taken and passed either the state board examination, National Boards Parts 1, 2, and 3, FLEX, USMLE, COMLEX-USA, NBOME or a combination thereof. Examination cannot have been taken more than four times;
- If a medical competency examination has not been taken within 10 years of application, the applicant must be board certified or re-certified through the American Board of Medical Specialties within the past ten years or the applicant must take and pass SPEX (Special Purpose Examination) administered through the Federation of State Medical Board, Inc.

Qualifications for Licensure - Podiatry

- Be at least twenty-one years of age;
- Be a citizen of the United States;
- Be of good moral character;
- Present a diploma or certificate of graduation from a school or college of podiatry approved by the Louisiana State Board of Medical Examiners;
- Pass an examination from the Board that shall be written, oral or clinical or any combination thereof as determined by the Board. The required examination is the PMLexis.

Instructions for Completing the Application

Section 1 - Indicate your licensure category. Statement of Legal Name - Record your name as it appears on each document listed that applies to you. This form must also be completed by any person whose name is not the same as the name on the diploma received from the professional school. This form must be notarized.

Section 2 - Personal appearance - Board members are located throughout the state, indicate which city you would prefer to make the personal appearance.

Section 3 - Address - Indicate the current mailing, permanent, and business address.

Section 4 - Current telephone numbers

Section 5 - Current web site and e-mail addresses

Section 6 - Date/Place of Birth

Section 7 - Nationality/Citizenship

Section 8 - Identification Numbers (if applicable)

Section 9 – Gender

Section 10 - Physical Description

Section 11 - Military Service

Section 12 - Licenses/Permits/Registration/Certification - List all licenses (temporary or permanent) that you have ever held whether it is now active, inactive or expired.

Section 13 - Third party authorization - Read and have this form notarized.

Section 14 - Controlled Substance Permits - Indicate State/Federal DEA numbers and the state for which it is issued.

Section 15 - Examination History - Indicate the examination taken, number of attempts, and the state for which the examination was taken. List all that apply. There is a limit on the number of times an applicant can take the examinations. The limit applies whether the examination was taken in Louisiana or in another state.

USMLE

- USMLE Step 1 - no limit
- USMLE Step 2 - four (4)
- USMLE Step 3 - four (4)

COMLEX-USA

- COMLEX - USA 1 - no limit
- COMLEX - USA 2 - four (4)
- COMLEX - USA 3 - four (4)

Plus

- Board certification through the American Board of Medical Specialties

NBOME

- NBOME - Part 1
- NBOME - Part 2 - four (4)
- NBOME - Part 3 - four (4)

plus

- Board Certification through the American Board of Medical Specialties

NBME

- NBME Part 1
- NBME Part 2 - four (4)
- NBME Part 3 - four (4)

If on the basis of FLEX:

- Pre-1985 - four (4)
- Post-1985 - Component I - four (4) Component II - four (4)

Acceptable combination of exams:

- FLEX Component I
  plus
- USMLE Step 3

_____

- NBOME Part 1
- NBOME Part 2
  plus
- COMLEX - USA 3

_____

- NBME Part 1
- NBME Part 2
  plus
- USMLE Step 3

- NBME Part 1
- NBME Part 2
  plus
- FLEX Component 2

_____

- PMLexis - Parts 1, 2 and 3

NOTE: If the applicant has not taken and passed a written medical competency examination within ten (10) years of filing the application, the applicant must take and pass SPEX or the American Board of Medical Specialties examination. To register for the SPEX examination, contact the Federation of State Medical Boards, Inc. (FSMB).

Section 16 - Premedical/professional Education - List your education. Account for all time from high school to the present.

Section 17A - Medical/Professional Education - List the professional education - the place where you received your Medical/Osteopathic/Podiatry Degree. List all professional schools attended in chronological order.

Section 17B - Practice History and Non-Professional Activities - List the practice history and non-medical/professional related activities here. Do not include training.

Section 18 - Fifth Pathway - Complete only if applicable. This section does not apply to U.S./Canadian graduates or Podiatrists.

Section 19 A & B - Postgraduate Medical Training - List all postgraduate training done in the United States or Canada in chronological order.

Section 20 - Specialty of Practice - Indicate your specialty.

Section 21 - Future Practice - Indicate where you plan to practice once you relocate to Louisiana.

Section 22 - Medical/Professional Graduate Type - U.S./Canadian or International

Oath and Affirmation - Read, answer and have this form notarized. Any "yes" answer(s) must be accompanied by a notarized affidavit. The applicant must explain in detail the incident(s) in which he/she is answering yes to and have the explanation notarized. This includes offenses that may have occurred as a juvenile and that may have been expunged from your record.

Certificate of Dean/Registrar/Program Head/Chairman - Applicant must complete the top section and attach a photograph. The photograph must be notarized as stated on form. After completing the required sections, mail it to the professional school for completion.

Verification of Internship or Equivalent Program - Applicant must complete the top section and mail it to their internship program for completion.

Verification/Endorsement - If you named any state (including District of Columbia, Puerto Rico, Guam, Canada) on section 12 of the application, send a copy of this form to each of those states for completion whether the license issued was permanent, temporary or is now expired. It is suggested that you contact each state to inquire as to whether or not that state has any requirements that must be fulfilled before it will complete our form. Most states charge a fee and will not complete the form until that fee is paid. You may make as many machine copies of this form as is necessary.

Certificate of Medical/Professional Society - The Executive Officer of the local county medical/professional society completes the appropriate section of the form. The seal of the society is to be impressed on the form. If the society does not have a seal, that fact must be verified on the form by the Executive Officer of the society. Applicants who are not members of a local/county/parish medical/professional society are required to provide an explanation on the form.

GENERAL INSTRUCTIONS

The state of Louisiana does criminal background checks as part of the application process through the state (Louisiana Department of Public Safety and Corrections (DOC) and Federal Bureau of Investigations (FBI). Materials for this purpose can be obtained by writing to:

LSBME
Attn: CB
P O Box 30250
New Orleans, LA 70190-0250

or by e-mail at lsbmemat@lsbme.louisiana.gov

Applicants with criminal history may expect delays in the application process

Notarized Birth Certificate - The applicant must submit a notarized copy of the birth certificate or a notarized copy of the passport (expired passports are acceptable). If the applicant submits a passport, the applicant must include a written explanation of the reason the birth certificate is not available.

Valid Visa - Applicants who are not native-born citizens of the United States must show proof of legal entry into the United States to work or reside by presenting:

- Original Certificate of Naturalization
- Birth Certificate establishing birth to U.S. citizens traveling abroad
- Valid Visa issued by the Department of Immigration and Naturalization (INS)

Character Recommendation(s) - Two are required for MD's/DO's - one for Podiatry from physicians/podiatrist other than relatives attesting to the applicants' good moral character and who have known the applicant for at least six months prior to filing the application.

Personal Appearance - Applicants should contact this office regarding the personal appearance. Appointments will only be scheduled after receipt of ***ALL*** application materials. At the time of the personal appearance, the applicant must present the ***ORIGINAL*** of the following documents (copies should have already been provided). All documents required to be presented must be in English. If the document(s) is not in English, they must be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of the law.

- Medical/Professional school diploma with English translation.
- If application is based on reciprocity/endorsement, the license of the state that FLEX/USMLE Step 3 was taken for and passed.
- Medical school transcripts (International Medical Graduates only).

- Marriage license and/or court decree of the applicant who applies in a name different from the name on the medical diploma.

- If not a native born citizen of the United States, you must present either a Certificate of Naturalization, a birth certificate identifying you as having been born to American parents while abroad or a valid visa which allows you to work and reside in the United States.

Graduates of international medical schools must also present the original of the:
- Current ECFMG certificate;
- Intern, residency/fellowship certificate(s).

Graduates of international medical schools must also provide a letter from the chief of services of all internships/residencies/fellowships served in the United States or Canada. The letter must give the inclusive dates of training and performance. It is not necessary to provide certificates or letters for training in a country other than the United States.

FEES ARE NOT REFUNDABLE and must accompany the application - $382.00 (MD/DO) $182.00 (Transfer from GETP) and $300.00 for Podiatry - additional $100.00 if applying for a temporary permit). It should be noted that should the check be returned for any reason, you will be required to resubmit the fee in the form of a money order and there will be an additional charge of $10.00.
Federation Credentials Verification Service (FCVS) - Applicants for licensure who are in the process of seeking employment and/or applicants for licensure/certification by multiple states and/or multiple entities (i.e. hospitals, insurance companies) that require primary source verification should consider applying with the Federation of State Medical Boards Credentials Verification Service (FCVS). For more information on the FCVS process, visit the website at www.fsmb.org.

Contact Addresses

Federation of State Medical Boards, Inc. (FSMB)
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
(817) 868-4000
Website: www.fsmb.org

Educational Council for Foreign Graduates (ECFMG)
3624 Market Street, Fourth Floor
Philadelphia, PA 19104-2685
(215) 386-5900

The Chauncey Group International
664 Rosedale Road
Princeton, NJ 08540-2218
(609) 720-6500

The National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3102
(215) 590-9500

The National Board of Osteopathic Examiners, Inc.
8765 West Higgins Rd, Suite 200
Chicago, IL 60631-4101
(773) 714-0622

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
(847) 491-9091

FREQUENTLY ASKED QUESTIONS

How long does the application process take?
The initial application process could take anywhere from a few weeks to several months to complete. Once the file is complete, it must be presented to the board for final consideration. Once a decision is made, the applicant is notified by mail within a week to ten days.

How is the application processed?
Applications are processed in the order in which they are received. One application is not given priority over another.

What is the deadline for the application to be presented to the Board for consideration?
The deadline is two weeks prior to a scheduled meeting. The application must be complete in every respect in order to be presented. If not, the application will have to wait until the next meeting. Board meetings are not held in the months of April and November.

I need a license immediately. How can you help me?
Applications are processed on a first come first serve basis.

Can I be issued a temporary license to practice medicine?
No. The state of Louisiana does not issue a temporary license to practice medicine. We do not issue a locum tenens license. The only temporary license issued for the practice of medicine is an interim. The interim license is only issued after the application is complete and has been presented to the Board and approved pending receipt of the results of the criminal background check.

Can I be issued a temporary permit to do residency/fellowship training?
Yes. The state of Louisiana does issue a permit for training purposes only.

I am completing my internship/residency in June. How soon can I apply for a permanent license?
A U.S./Canadian graduate may apply for licensure four months prior to completion of the internship/residency. An international graduate can apply four months prior to completion of the third year of training. The required three years of postgraduate approved training must be in the same specialty.

I have decided not to relocate to Louisiana. Can I withdraw my application? Is the fee refundable?
To withdraw an application, you must notify the Board in writing. No fees are refundable.

What does "primary source verification" mean?
The term means that all information is received directly from the issuing agency.

Does Louisiana accept the LMCC of Canada for license? Even if I have a license in another state?
No.

Is there a difference between being a Medical Doctor and being a Doctor of Osteopathy when issuing a medical license?
No. All are classified as physicians and are issued the same type of medical license.

Can I practice in Louisiana with a license from another state?
Not unless you are practicing in a federal institution or military base.

What does "Board Certified" mean?
Board certified means that you have taken and passed an oral and written examination in your specialty.

What fees are involved in the application process?
There is a non-refundable license fee of $382.00 (MD/DO), 182.00 (Transfer from GETP) and $300.00 (Podiatry) made payable to the Louisiana State Board of Medical Examiners and must accompany your application. A $50.00 **money order** is required for the criminal background check. The money order is made payable to the Department of Public Safety and Corrections.

How many attempts are allowed on FLEX/USMLE/NBOME/COMLEX-USA/SPEX/NBME?
Four

Will I have to take an additional examination for licensure?
Only if it has been over ten years since a medical competency examination was taken and passed from the date of filing an application. The required examination is SPEX or a specialty board certification or re-certification examination.

If I have had my fingerprints cleared by another state or agency, will Louisiana accept them?
No.

Do I need to send my ORIGINAL or a notarized copy of my documents with the application?
No. A copy of the aforementioned documents should be submitted with your application. All original documents are presented at the personal appearance.

Can a family member, friend, spouse or telephone call take the place of appearing in person for the interview?
No.

I have a license in another state. Do I have to go through the application process again?
Yes.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

FEE SCHEDULE FOR MD/DO/POD

(Rev 050104)

Initial Licensure Fees

Note: If applying for a temporary permit, permanent licensure fee must accompany the temporary permit fee.

Profession		Form Of Payment	Payable To	Amount	Send To	*Total*
ALL APPLICANTS: ***FINGERPRINTS***		Money Order	La. Department of Public Safety and Corrections	$50.00	LSBME	$50.00
For LSBME to return documents to applicant in U.S. by U.S. Certified Mail, Return Receipt Requested.		Check or Money Order	LSBME	$2.55	LSBME	$
For LSBME to return documents to applicant in U.S. by courier.		***SEE INSTRUCTIONS***				----------
RECIPROCITY	Physicians And Surgeons (U.S. Or IMG)	Check or Money Order	LSBME	$382.00	LSBME	$
	Podiatrist	Check or Money Order	LSBME	$300.00	LSBME	$
MD/DO	Transfer from PGY-1 Status	Check or Money Order	LSBME	$232.00	LSBME	$
	Graduate Education Temporary Permit(GETP)	Check or Money Order	LSBME	$200.00	LSBME	$
	Transfer from GETP Status	Check or Money Order	LSBME	$182.00	LSBME	$
	Dispensing Registration	Check or Money Order	LSBME	$75.00	LSBME	$
	Institutional Permits	Check or Money Order	LSBME	$100.00	LSBME	$
	Military Physician Permit	Check or Money Order	LSBME	$100.00	LSBME	$
	Military Intern Permit	Check or Money Order	LSBME	$50.00	LSBME	$
	Post Graduate Year One Registration (PGY1;PGY2)	Check or Money Order	LSBME	$50.00	LSBME	$
	Short Term	Check or Money Order	LSBME	$100.00	LSBME	$
	Physicians And Surgeons- Retired	Check or Money Order	LSBME	$150.00*	LSBME	$
	Visiting Physicians	Check or Money Order	LSBME	$100.00	LSBME	$
PODIATRIST	Podiatrist	Check or Money Order	LSBME	$300.00	LSBME	$
	Podiatrist Temporary Permit	Check or Money Order	LSBME	$100.00	LSBME	$
	Podiatrist Residency Training Permit	Check or Money Order	LSBME	$50.00	LSBME	$
TOTAL						$

*Must Complete Waiver Form

NOTE: The LSBME will notify applicant if insufficient monies are remitted.

Renewal Fees[1]

Medicine & Surgery/DO/INST due on or before the first (1st) day of licensee's birth month.		
Medicine & Surgery/Do/Inst	Scheduled Renewal Fee $332.00	If After First (1st) Day of Your Birth Month $632.00
If Reduced Fee[2]	Scheduled Renewal Fee $150.00	If After First (1st) Day of Your Birth Month $300.00
Podiatrists	Scheduled Renewal Fee $200.00	

[1] Fees are not prorated (i.e. License received mid-year fee payable in full, next annual renewal payable in full)

[2] See Application for Reduction in Renewal Fee for Physicians. LAC 46:XLV, Subpart 2, Chapter 3, Subchapter I, §418. (Rev. 040202)

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS—New Orleans, Louisiana

MD/DO/Podiatry Initial Application for Permit/License/Certification--

It is unlawful to file false public records in any public office or with any public official. ***Refer to the application instructions when completing these forms. Carefully prepare responses.*** **(Rev 121902)**

Area for Licensure, Permitting, Registration and/or Certification Check all that apply. Specify the purpose and discipline of licensure application. Type or block print only. Do not use felt-tip pens.	___ First medical license ____ Licensure by endorsement ____Medicine & Surgery _____ Institutional ____Osteopathy _____Podiatry
1. Name(s)— Use *full* name. Do not use initials or nicknames unless they are part of your legal name. Line 1: Surname (including Jr., Sr., II, etc.) and degree; Line 2: First and Middle Name(s). If name is hyphenated, include the hyphen. List your name as it appears on each document. **1a. License, Permit, Registration and/or Certification—This Is Your Legal Name.** This is the name that will be printed on your license, permit, registration and/or certification and used for all reporting and on inquiries. Use this name on each page of the application. **1b. Medical/Professional Diploma.** **1c. Internship / Residency** Include name and location of hospital(s). **1d. ECFMG Certificate**. **1e. NBME, USMLE, FLEX, SPEX, PMLexis, Other Certificate(s).** Specify certificate by placing "X" in appropriate blank. **1f. State License(s), Permit, Registration and/or Certification.** Identify State. **1g. Specialty Board Certificate(s) Identify Board.** **1h. Certificate of Naturalization, Declaration of Intention, Valid visa Specify.** **1i. All other Alternate Names—**Include ***all*** other names and nicknames (including names used for/in Board Actions). Statement of Legal Name: ***Sworn Before a Notary***	**1a.** _____ _____ **1b.** _____ _____ **1c.** _____ _____ _____ Hospital and Location **1d.** _____ _____ **1e.** _____ _____ ____NBME ____USMLE ____FLEX ____SPEX ____PMLexis _____Other (specify): **Certificate Number:** _____ **1f.** _____ _____ _____ **State** **1g.** _____ _____ **1h.** _____ _____ **1i** _____ _____ ***Statement of Legal Name*** I understand that the Louisiana State Board of Medical Examiners maintains all records in alphabetical order and that I will be listed alphabetically under my surname (last name) as stated in Item 1a of this Application. _____ Signature Subscribed and sworn on this _____ day of _____, in the year 200____. _____ Notary Public _____ My Commission Expires *SEAL*

Insert Name: Same as 1a

2. Personal Interview

State the preferred location for personal interview with original credentials. Personal interview shall not be made until application is otherwise complete.

MD/DO

If does not apply, mark "X" here: ☐

_____New Orleans _____Morgan City

_____Baton Rouge _____Shreveport

_____Lafayette

If intern/resident, mark "X" here: _____

Podiatry

_____New Orleans _____Monroe

3. Addresses

Address ***must*** include physical address (i.e. street number, street name). If applicable, include apartment number with physical address.

3a. Mailing—This is the address to which correspondence will be forwarded by the LSBME. *This is the address that will appear in the *LSBME Official List* and will be provided to the public.

It is your responsibility to keep the LSBME apprised of all address changes.

3b. Permanent– If same as mailing address, mark "X" here: ☐

3c. Business Address
This is NOT the MAILING or PERMANENT addresses listed in items 3a and 3b.

3a. _____
Physical Address

_____
Post Office Box, If Applicable

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

3b. _____
Physical Address

_____
Post Office Box, If Applicable

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

3c. _____
Physical Address

_____
Post Office Box, If Applicable

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

4. Telephone Numbers

International Country Code _____

_____ - _____ Ext. _____
Business Phone

_____ - _____
Home Phone

_____ - _____
Business Fax

_____ - _____
Home Fax

_____ - _____ Ext. _____
Cell Phone

_____ - _____
Pager

5. Website and E-mail Address

List primary and secondary e-mail addresses, if applicable.

_____
Website Address

_____
Primary E-mail Address

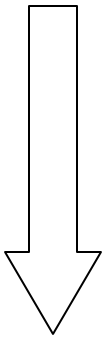
_____
Secondary E-mail Address, If Applicable

Insert Name: Same as 1a	
6. Date and Place of Birth Notarized birth certificate or passport required. If passport submitted, explain on separate 8 ½ "x 11" sheet of paper.	_____ _____ _____ Month Day Year _____ City Parish/County State (US only) _____ Province/Territory _____ Country
7. Nationality/ Citizenship If not native born U.S. citizen (born in U.S. or one of its territories), proof of U.S. citizenship or valid visa issued by U.S. Immigration and Naturalization required. Proof of U.S. citizenship can be by producing an *original* certificate of naturalization or certificate of birth to U.S. citizens traveling abroad. A valid visa is a visa issued by the Immigration and Naturalization Service authorizing a person to reside and work in the U.S. *No license or temporary permit for practice in Louisiana will be issued without production of above credentials.*	a. Are you an U.S. Citizen? ☐ Yes ☐ No b. If not native born citizen of the U.S., provide following: Type VISA: _____ If naturalized, provide certificate number: _____ INS number: _____ Petition number: _____ Date issued: _____ District Court through which issued: _____ Certificate of Citizenship certificate number: _____
8. Identification Numbers	_____ - _____ - _____ _____ _____ U.S. Social Security Number Driver's License Number Issuing State _____ National Identification Number _____ Issuing Country
9. Gender	_____ Male _____Female
10. Physical Description See Instructions for LSBME Code Descriptions. Use linear measure in feet and inches.	Height _____ Weight_____ Eyes _____ Hair_____ Race _____ Ft. In. Lbs. Color Color Optional ____I have no physical mark(s). ____I have the following physical mark(s): _____ Description of Mark Location _____ Description of Mark Location
11. Military U.S. Active Duty	Have you ever served in the U.S. Military? ☐ Yes ☐ No *If yes,* Branch _____ Dates Served _____Type Discharge _____

Insert Name: Same as 1a	
12. License/Permit/ Registration/ Certification History List States in which you obtained a License, Permit and/or Certification. Specify type, license number and date initially issued. Include ***all*** licenses, whether permanent or temporary. Does not apply, mark here ☐	Louisiana _____ Date _____ Other States: _____ Date_____ _____ Date_____ _____ Date_____ _____ Date_____

To order criminal background materials, e-mail the LSBME here: lsbmemat@lsbme.louisiana.gov . ***Include the following information: Name, Mailing Address, and Telephone Number.***

CONTINUE TO THE NEXT PAGE



Insert Name: Same as 1a	
13. Third-Party Authorization	***THIRD PARTY AUTHORIZATION*** I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto. By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me. The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services. I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original. Signature: _____ Full Name ****TO BE SIGNED IN THE PRESENCE OF A NOTARY** Subscribed and sworn to before me this _____ day of _____, 20 _____. _____ Notary Public ***Seal*** MY COMMISSION EXPIRES: _____

Insert Name: Same as 1a	
14. Controlled Substance Permits Provide permit numbers and status. If permit not current, explain. If item does not apply, mark, "Does not apply".	Drug Enforcement Administration (DEA) _____ Current? ☐ Yes ☐ No State _____ Does not apply ☐
15. Examination History Medical Doctors If does not apply, mark "X" here: ☐ Provide the most recent examination date and total number of attempts for each examination you have taken for purposes of state medical licensure. Many applicants confuse NBME Parts with USMLE Steps. Please be certain to accurately report your examination history. Incorrectly reported examinations will result in delays and additional verification surcharges. State Board examinations are those that were developed and administered specifically by state licensing authorities. Some states have never administered state board examinations and therefore do not apply. Do not confuse these examinations with national licensing examinations such as the NBME, NBOME or USMLE. If additional space is necessary to report multiple attempts for any test listed, specify here or provide additional information on separate 8 ½ " x 11" paper.	**Examination** / **Most Recent Attempt (Month/Year)** / **No. of Attempts** / **State Board Sponsor** State Board Exam _____ _____ _____ FLEX Pre-1985 _____ _____ _____ FLEX Component I _____ _____ _____ FLEX Component II _____ _____ _____ NBME Part I _____ _____ _____ NBME Part II _____ _____ _____ NBME Part III _____ _____ _____ SPEX _____ _____ _____ USMLE Step 1 _____ _____ _____ USMLE Step 2 _____ _____ _____ USMLE Step 3 _____ _____ _____ ECFMG _____ _____ _____ NBOME 1 _____ _____ _____ NBOME 2 _____ _____ _____ NBOME 3 _____ _____ _____ COMLEX-USA 1 _____ _____ _____ COMLEX-USA 2 _____ _____ _____ COMLEX-USA 3 _____ _____ _____ PMLexis _____ _____ _____ National Boards Part 1 _____ _____ ☐ Pass ☐ Fail Part 2 _____ _____ ☐ Pass ☐ Fail **Additional Information**_____

Insert Name: Same as 1a

16. Premedical Education

If you are a graduate of a medical school in the U.S. or Canada, complete this item and Item 17. Do not complete Item 18.

If you are a graduate of a medical school outside the U.S. or Canada, completed this item, Item 17 and Item 18. Fifth Pathway, if applicable.

List high school and all colleges and/or universities you attended **prior** to medical and/or allied health school in chronological order, most recent listed first.

You may photocopy this page to report more than four (4) institutions, if necessary.

Account for **ALL** time since high school. If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates of this break at section 17B. It is not necessary to report breaks between institutions.

Combined MD/PhD programs should be reported in Item 17.

Note:
LSBME does not verify premedical education (except in cases where credits were granted towards the medical degree.) The information provided will be reported exactly as it appears on this page.

Name of Institution #1

Address

City State

Country Zip Code Plus 4

From _____ _____ To: _____ _____ Degree: ☐ None ☐ **High School**
Month Year Month Year ☐ B.A. ☐ B.S.
☐ M.A. ☐ M.S.
☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

---

Name of Institution #2

Address

City State

Country Zip Code Plus 4

From _____ _____ To: _____ _____ Degree: ☐ None ☐ **High School**
Month Year Month Year ☐ B.A. ☐ B.S.
☐ M.A. ☐ M.S.
☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

---

Name of Institution #3

Address

City State

Country Zip Code Plus 4

From _____ _____ To: _____ _____ Degree: ☐ None ☐ B.A. ☐ B.S.
Month Year Month Year ☐ M.A. ☐ M.S.
☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

---

Name of Institution #4

Address

City State

Country Zip Code Plus 4

From _____ _____ To: _____ _____ Degree: ☐ None ☐ **High School**
Month Year Month Year ☐ B.A. ☐ B.S.
☐ M.A. ☐ M.S.
☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐ Yes ☐ No

Insert Name: Same as 1a	

17A. Medical Education

If does not apply, mark "X" here: ☐

List all of the medical schools attended in chronological order, beginning with most recent school attended.

Photocopy this page to report more than two (2) institutions, if necessary.

If medical school is outside of the U.S. and/or you participated in a Fifth Pathway program, also complete Item 18.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8 ½" x 11"sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION:

Include a legible photocopy of medical school diploma.

Complete Name of Institution # 1 (Do Not abbreviate)

Street Address, City, State, Country (if not U.S.), Zip Code

Month / Date / Year Commenced — Month / Date / Year Graduated

____ MD ____ D.O. ____Podiatry _____ Did not graduate.

Unusual Circumstances (check Yes or No)

Did you take a leave(s) of absence or break(s) from your medical education?..... ☐ Yes ☐ No

Were you ever placed on probation?..... ☐ Yes ☐ No

Were you ever disciplined or placed under investigation?..... ☐ Yes ☐ No

Were any negative reports ever filed against you?..... ☐ Yes ☐ No

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason?..... ☐ Yes ☐ No

Please explain each "Yes" response from above:

Complete Name of Institution # 2 (Do Not Abbreviate)

Street Address, City, State, Country (if not U.S.), Zip Code

Month / Date / Year Commenced — Month / Date / Year Graduated

____ MD ____ D.O. ____Podiatry _____ Did not graduate.

Unusual Circumstances (check Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?..... ☐ Yes ☐ No

Were you ever placed on probation ..... ☐ Yes ☐ No

Were you ever disciplined or placed under investigation?..... ☐ Yes ☐ No

Were any negative reports ever filed against you?..... ☐ Yes ☐ No

Were any limitations or special requirements imposed on you because of Academic incompetence, disciplinary problems or for any other reason?..... ☐ Yes ☐ No

Please explain each "Yes" response from above:

Insert Name: Same as 1a					
17B. Practice History and Non-Professional Activity (Do NOT include Training) Account for ALL time, in chronological order, from High School to the present.	**From Month/Year**	**To Month/Year**	**Location City/State**	**Employer/Practice**	**Specialty/Activity**

18. Fifth Pathway

Complete this section only if you participated in a Fifth Pathway Program

The LSBME will contact you with special instructions upon receipt of your application and fees.

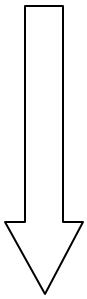
DOCUMENTATION
You must include a legible photocopy of your Fifth Pathway Certificate.

If does not apply, Mark "X" here ☐

_____
Complete Name of Medical School that Awarded Fifth Pathway Certificate. (Do Not Abbreviate)

_____
Street Address, City, Parish / County, State, Country (if not U.S.)

_____
Month / Day / Year Commenced Month / Day / Year Completed Exact Date (Month / day / Year)Certificate Awarded



CONTINUE TO NEXT PAGE

Insert Name: Same as 1a	

19A. Postgraduate Medical Education

List all of the postgraduate medical education programs attended in chronological order. Use one page per institution.

Two pages in this application are provided to report this information. You must make a photocopy (ies) of this page to report more than two (2) institutions.

IMPORTANT:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If postgraduate year is cur rently in progress, indicate the *expected* completion date in the "To" field.

Report internships, residencies and fellowships separately.

Use one section per department.

If necessary, continue your explanation of Unusual Circumstances on a separate 8½ "x 11" sheet of paper. Response may not exceed 100 words per question

If does not apply, mark "X" here ☐

Use one (1) page per institution. This page represents _____ of _____institutions.

_____
Complete Name of hospital where training was conducted (Do Not Abbreviate).

_____
Complete Name of affiliated university or college (Do Not Abbreviate).

_____
Address Line 1

_____
Address Line 2

_____
City, Providence / State, Country (US or Canada Only)

_____
Zip / Postal Code plus 4

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

Unusual Circumstances (check Yes or No):

- Did you take leave(s) of absence or break(s) from your medical education?..... ☐ Yes ☐ No
- Were you ever placed on probation?..... ☐ Yes ☐ No
- Were you ever disciplined or placed under investigation?..... ☐ Yes ☐ No
- Were any negative reports ever filed against you?..... ☐ Yes ☐ No
- Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason?..... ☐ Yes ☐ No

Explain each "YES" response from above:_____
_____
_____
_____

Insert Name: Same as 1a

19B. Continued Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. Use one page per institution.

Two pages (Items 19A and 19B) in this application are provided to report this information. You must make a photocopy (ies) of this page to report more than two (2) institutions.

IMPORTANT:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If postgraduate year is currently in progress, indicate the *expected* completion date in the "to" field.

Report internships, residencies and fellowships separately.

Use one section per department.

If necessary, continue your explanation of Unusual Circumstances on a separate 8 ½" x 11" sheet of paper. Response may not exceed 100 words per question.

If does not apply, mark "X" here ☐

Use one (1) page per institution. This page represents _____ of _____institutions.

_____
Complete Name of hospital where training was conducted (Do Not Abbreviate).

_____
Complete Name of affiliated university or college (Do Not Abbreviate).

_____
Address Line 1

_____
Address Line 2

_____
City, Providence / State, Country (US or Canada Only)

_____
Zip / Postal Code plus 4

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

PGY: _____ Internship: _____ Residency: _____ Fellowship: _____

Department:
_____

From: _____ - _____ **to** _____ - _____
Month Year Month Year

Successfully Completed? _____ Yes _____ No _____ In progress

Unusual Circumstances (check Yes or No):

- Did you take leave(s) of absence or break(s) from your medical education?..... ☐ Yes ☐ No
- Were you ever placed on probation?..... ☐ Yes ☐ No
- Were you ever disciplined or placed under investigation?..... ☐ Yes ☐ No
- Were any negative reports ever filed against you?..... ☐ Yes ☐ No
- Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason?..... ☐ Yes ☐ No

Explain each "YES" response from above:_____
_____
_____
_____

Insert Name: Same as 1a	
20. Specialty of Practice See "Description of Codes" in Instructions. DOCUMENTATION: Provide a notarized copy of your ABMS certificate(s). If necessary, you may continue your report of information regarding certification and recertification on a separate 8 ½ " x 11" sheet of paper. If does not apply, mark "X" here ☐	_____ Board Certified/Recertified? *Check one:* ☐ Yes ☐ No Primary Specialty Code[3] If Yes, Year Certified: _____ Year If Yes, Year Recertified: _____ Year _____ Board Certified? *Check one:* ☐ Yes ☐ No Secondary Specialty Code[2] If Yes, Year Certified: _____ Year If Yes, Year Recertified: _____ Year
21. Future Practice Information Specify when and where in the State of Louisiana practice is intended and list type of practice. FEL = Fellowship OFC = Office GRP = Group FTY = Facility HSP = Hospital HMO = HMO OTH = Other If necessary, you may continue on a separate 8 ½" x 11" sheet of paper. If does not apply, mark "X" here: ☐	Location #1 _____ _____ City Practice Type (See Codes) _____ Date Anticipated Location #2 _____ _____ City Practice Type (See Codes) _____ Date Anticipated Location #3 _____ _____ City Practice Type (See Codes) _____ Date Anticipated
22. Medical Doctor Graduate Type DOCUMENTATION: If graduated from a medical school outside the U.S. or Canada, submit 1 requests for certification of ECFMG Certificate ***from the ECFMG.*** The LSBME will not accept certification from the applicant. See special instructions. If does not apply, mark "X" here: ☐	____ U.S./Canadian ____International (other than Canada) ECFMG Number _____ - _____ - _____ - _____ Date issued _____ _____ _____ Month Day Year Current, Valid ECFMG Certification? _____ Yes _____ No

[3] You may report "None", "Other" or "Unknown", if necessary.
[2] You may report "None", "Other" or "Unknown", if necessary.

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

OATH OR AFFIRMATION

Answer the following questions
(Yes answers must be explained in sworn affidavit *-AFFIDAVIT MUST BE TYPED!*)

		YES	NO
1.	In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2.	In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3.	Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute?		
	b) Federal statute?		
4.	Has your application for examination or license ever been rejected or denied?		
5.	Have you ever failed a licensure/certification examination? If yes, how many times?_____		
6.	Have you ever been denied membership in a state, county, or local professional society?		
7.	Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8.	Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9.	Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10.	Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
11.	Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12.	Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13.	Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14.	Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15.	Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____
Full Name

Subscribed and sworn to before me this _____day

of_____YEAR_____

_____
NOTARY PUBLIC

My commission expires_____

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

CERTIFICATE OF DEAN/REGISTRAR

APPLICANT'S NAME

_____

SOCIAL SECURITY NUMBER

_____

Section 1: To Applicant—Complete Section 1 before a Notary. Forward this form to your Medical, Osteopathic or Podiatry School.

Recent photograph

Passport quality photograph of applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

Notary is to affix seal directly on photograph.

Affix Photograph Here
(Follow directions carefully.)

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____Day of _____, 200_____

_____
Notary Public

My commission expires_____

Section 2: To Dean/Registrar of Medical/Osteopathic/Podiatry School

After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree of, or certificate in, _____

Dated _____from this school.

_____ _____
Name of school/program Signature of Medical Dean/Registrar, Allied Program Chairman/Head

_____ _____
Address Title

_____
Date

Affix School Seal Here

Louisiana State Board of Medical Examiners
P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

VERIFICATION OF INTERNSHIP OR EQUIVALENT PROGRAM (MD and DO only)

Section 1: **TO THE APPLICANT--In order to be eligible for licensure in Louisiana, an applicant who is a graduate of a U.S. or Canadian Medical School or college must present proof of having completed at least one year of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the Royal College of Physicians and Surgeons (RCPS) of Canada and approved by the Board.**

Complete the top section of this form and then forward it to the Director of Medical Education or Program Chairman for completion of the bottom section.

To Whom This May Concern at _____:

I am applying for license to practice medicine in the state of Louisiana. This is your authorization to release all information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
Print Or Type Your Full Name Signature

_____
Address

_____
City, State and Zip Code

Section 2**: To be completed by the Director of the Hospital or by the Director of Medical Education and returned directly to: Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.**

Re:_____
(Applicant's name)

This to verify that the records of this institution indicate that the referenced physician served an Internship or Equivalent Program as follows:

Dates of Internship (PGY-1): Start Date:_____; End Date:_____

Type of Internship served: _____Transitional; _____Rotating; _____Categorical (specify specialty)_____

Did the physician successfully complete the Internship? _____Yes; _____No.

Please explain

_____

_____

_____

Date:_____ Signed:_____

Title:_____

(Seal of Institution) Name of Institution:_____

Address:_____

TO BE WRITTEN ON OFFICIAL LETTERHEAD OF SCHOOL

SAMPLE LETTER OF RECOMMENDATION FROM DEAN/PRINCIPAL/ADMINISTRATOR
(Sample for International Medical Graduates Only)

Date_____

Louisiana State Board of Medical Examiners
Post Office Box 30250
New Orleans, LA 70190-0250

Gentleman:

This is on behalf of _____ who has asked this office for a recommendation in support of
(Applicant's name)
his/her application to the Louisiana State Board of Medical Examiners.

The above-named applicant graduated from _____
_____ after having completed the prescribed studies.

We remember him/her as a person of fine moral character and with good command of the English language.

We fully endorse his/her application and any assistance extended to him/her in his/her desire to practice his/her profession in your State will be highly appreciated.

(Seal)

_____
Signature

_____
Title

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

******To be completed if applying based on reciprocity******

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
TYPE OR PRINT YOUR FULL NAME SIGNATURE

_____ _____
LICENSE NUMBER AND DATE ISSUED ADDRESS

_____ _____
SOCIAL SECURITY NUMBER CITY, STATE, ZIP CODE

Section 2: **THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORSING STATE** ***and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.***

A. This is to certify that the records of the licensing Board of the State of _____indicate that the above-named individual was issued license/certificate No**.**_____ dated_____ on the basis of written examination (state name of examination)_____; reciprocity with the state of _____; other basis (please name**)**_____.

B. *If State Board Examination,* provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ☐ Yes ☐ No ☐ Cannot Divulge
2. Is this license/certificate in good standing? ☐ Yes ☐ No ☐ Cannot Divulge
3. Has this individual ever been warned or reprimanded? ☐ Yes ☐ No ☐ Cannot Divulge
4. Has this individual license/certificate ever been revoked? ☐ Yes ☐ No ☐ Cannot Divulge
5. Has this individual license/certificate ever been suspended? ☐ Yes ☐ No ☐ Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ☐ Yes ☐ No ☐ Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ☐ Yes ☐ No ☐ Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ☐ Yes ☐ No ☐ Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ☐ Yes ☐ No ☐ Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ☐ Yes ☐ No ☐ Cannot Divulge

REMARKS_____

_____

_____ _____
Date Signature

_____
Title

BOARD SEAL _____
Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

(REV. 020201)

Louisiana State Board of Medical Examiners
P. O. Box 30250, New Orleans, LA 70190-0250
(504) 568-6820

REQUEST FOR EXAMINATION SCORES

To request the ***FLEX, SPEX*** or ***USMLE*** scores, you must complete the Federation's request form which can be obtained from their web site at **www.fsmb.org.**

To request the ***National Board*** scores, you must complete the National Board's request form which can be obtained from their web site at **www.nbme.org.**

To request the ***NBOME/COMLEX-USA*** scores, you must complete the National Board's Request form which can be obtained form their web site at **www.nbome.org.**

Contact the examination entity to determine monies necessary to request scores. See "Examination Contacts" on the LSBME application instructions. The LSBME will not accept scores from any source other than the examination entity.

Louisiana State Board of Medical Examiners
P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

CERTIFICATE OF MEDICAL/PROFESSIONAL SOCIETY (MD/DO only)

***Section 1: To Applicant*—**This form is to be forwarded to the local/county/parish medical/professional society for completion. Applicant is to place his/her name in the blank for name in Section 2. Applicant who is not a member of the local/county/parish medical/professional society is to provide an explanation to the Board.

Section 2: To be completed by the local county/parish medical/professional society and returned to the Louisiana State Board of Medical Examiners, Office of Licensure, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that

_____

is a member in good standing of this society.

_____ _____

Name of Society Signature of Executive Officer

_____ _____

Address Title

_____

Date

SOCIETY SEAL
(If no seal, please so state)

Louisiana State Board of Medical Examiners
P.O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

VERIFICATION OF BOARD CERTIFICATION/CREDENTIALS

The LSBME will NOT accept verification from any source other that the Certification/Credentialing Board.

Section 1: **To the applicant:** Complete Sections 1 & 2 then forward this form to the Board to which you have received Board Certification/Credentials.

_____ _____
Name of Certification/Credentialing Board — Applicant's Full Name

_____ _____
Street Address — City, State and Zip Code plus 4

Section 2: **To the Certification/Credentialing Board from the applicant:**
Gentlemen:
I am applying for licensure/reinstatement/re-licensure to practice in the State of Louisiana. This is your authorization to release any information in you files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
Print or Type Your Full Name — Signature

_____ _____
Street Address — City, State and Zip Code plus 4

_____
Date of Certification/Credentialing

Section 3: **To the Certification/Credentialing Board:** Mail verification of certification/credentials to: Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT return to applicant. The LSBME will NOT accept verification from any source other that the Certification/Credentialing Board.

Re: _____

Please certify that the records of the Board indicate the following regarding the above referenced physician:

- Certification/Credential Number
- Type of certification/credential
- Date of certification/credentialing
- Date of examination (if examination taken for certification/credentialing)
- Date certification/credentialing valid through
- Date of re-certification/credentialing
- Date of examination (if examination taken for re-certification/credentialing)
- Date re-certification/credentialing valid through